Washington State Department of Social & Health Services
Division of Alcohol and Substance Abuse

CAMPRAL® AUTHORIZATION

1. AGENCY SECTION

DIVISION OF ALCOHOL AND SUBSTANCE ABUSE (DASA) CERTIFIED CHEMICAL DEPENDENCY TREATMENT AGENCY	AGENCY NUMBER (USE NUMBER IN GREENBOOK "DIRECTORY OF CERTIFIED SERVICES IN WASHINGTON")

The certified chemical dependency treatment agency listed above verifies that the patient listed below is eighteen (18) years of age or older; alcohol dependent with alcohol dependency as the primary addiction; and has been admitted into publicly funded state-certified chemical dependency treatment. The Chemical Dependency Professional (CDP) providing services to this patient recommends that the physician named below determine the use of Campral® as a part of the patient's treatment plan.

CDP'S SIGNATURE DATE	CDP'S PRINTED NAME	CDP'S TELEPHONE NUMBER

2. PATIENT SECTION

PATIENT'S NAME	PATIENT'S MAA PIC NUMBER	DATE ADMITTED TO CHEMICAL DEPENDENCY TREATMENT

☐ Alcohol Dependent

PATIENT AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

I, _____(print patient's name) authorize the CDP and/or certified chemical dependency treatment agency indicated above to disclose my name and other personal identifying information, my status as a patient, my diagnosis, and their treatment recommendation(s) to my physician and pharmacy indicated below. I also authorize the physician and/or pharmacy named below to disclose information concerning my diagnosis, treatment recommendation(s), and recommended medication(s) to the CDP and/or certified chemical dependency treatment agency named above. The purpose of the disclosures authorized in this consent is to obtain a prescription for Campral®.

PRINT PHYSICIAN'S NAME	PRINT PHARMACY'S NAME

I understand that my alcohol and/or drug treatment records are protected under Federal and State Confidentiality regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 Code of Federal Regulations, Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 Code of Federal Regulations, Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows: either 90 days from the date signed, or the **following specific date, event, or condition upon which this consent expires:**

_____(date/event/condition).

I understand that generally _____

(insert name of certified chemical dependency agency) **may not condition my treatment on whether or not I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form.**

PATIENT'S SIGNATURE DATE	SIGNATURE OF GUARDIAN OR AUTHORIZED REP (WHEN REQUIRED) DATE

3. PHYSICAIN SECTION

PHYSICIAN'S NAME	TELEPHONE NUMBER	MEDICAID PROVIDER NUMBER

ADDRESS

Date ordered by physician:	Proposed treatment start date:

4. PHARMACY SECTION

PHARMACY'S NAME	MEDICAID PROVIDER NUMBER

I have received a prescription for Campral® for the patient named above from the patient's physician and have filled the prescription as authorized. I understand that reimbursement by Medical Assistance Administration (MAA) for Campral® shall only be made under the following conditions

1. The medication is provided as part of a comprehensive treatment program as verified by the certification provided above.
2. Payment for the medication is limited to twelve (12) months of continuous use.
3. The pharmacy shall include the prescribing physician's MAA Medical Provider number on the MAA billing form.
4. Record of this certification shall be kept on file at the pharmacy for MAA audit purposes. Prescriptions reimbursed by MAA for Campral® without this certification record on file shall be considered an overpayment.

PHARMACIST'S SIGNATURE DATE	TELEPHONE NUMBER

ADDRESS CITY STATE ZIP CODE

CAMPRAL® AUTHORIZATION
FORM INSTRUCTIONS

If a patient and "qualified physician" agree that Campral® may be an appropriate adjunctive treatment with DASA certified chemical dependency treatment and wish to seek payment for a prescription for the medication to be made by the state, a Campral® Authorization form must be completed.

1. Complete the **AGENCY SECTION**:
   - Enter the name of the DASA certified chemical dependency treatment agency and the agency's 8-digit certification agency identification number found in the "Directory of Certified Chemical Dependency Treatment Services in Washington State" (commonly known as the "Greenbook") located at http://www1.dshs.wa.gov/dasa/services/certification/GB.shtml, published by the Division of Alcohol and Substance Abuse, Department of Social and Health Services.
   - The patient's Chemical Dependency Professional (CDP) signs, dates, and enters telephone number at the end of this section.

2. Complete the **PATIENT SECTION**:
   - Enter the patient's name.
   - Enter the patient's Medical Assistance Administration (MAA) Patient Identification Code (PIC) number.
   - Enter the date the patient was admitted to chemical dependency treatment
   - Complete the **Patient Authorization for Disclosure of Confidential Information,** being sure the CDP discusses this disclosure with the patient and have the patient sign and date it (or their guardian or authorized representative, when required).

3. Complete the **PHYSICIAN SECTION**:
   - Enter the name of the physician and the physician's Medicaid Provider number.
   - Enter the date the physician determined the patient was in need of Campral® medication and the proposed treatment start date.

4. Complete the **PHARMACY SECTION:**
   - Pharmacist will ensure completion of all sections prior to Pharmacist's signature and dispensing.
   - The Pharmacist keeps the copy on file at the pharmacy for future MAA audit purposes.

The physician will give the patient copies of the Campral® Authorization form to take to the CDP, and then to the pharmacy to obtain the prescription.

- The physician should keep a copy of the Campral® Authorization Form for the medical record.
- The CDP at the chemical dependency treatment agency should keep a copy for the patient's record.
- The CDP will discuss and ensure completion of the **Patient Authorization for Disclosure of Confidential Information** with the patient.

Information about Patient's Right to Revoke Authorization: A revocation requires only that a line be drawn through the document, with the word "Revoked," and the date and time of revocation. The patient need not initial a revocation. A patient may request revocation by any means, including the telephone, provided their identity is confirmed.

The following notice should accompany all documents released under the Patient's Authorization for Disclosure of Confidential information on the other side of this form:

NOTICE PROHIBITING REDISCLOSURE
OF ALCOHOL OR DRUG TREATMENT INFORMATION

Prohibition on Redisclosure of Confidential Information

This notice accompanies a disclosure of information concerning a client in alcohol/drug treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by federal confidentiality rules, 42 Code of Federal Regulations (CFR), Part 2. The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR, Part 2. A general authorization for the release of medical or other information is **NOT** sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.